

STATE OF MAINE

STATE BOARD OF ALCOHOL AND DRUG COUNSELORS

APPLICATION FOR ALCOHOL AND DRUG COUNSELING AIDE



Department of Professional and Financial Regulation

Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8689
TTY/HEARING IMPAIRED (888) 577-6690
FAX: (207) 624-8637

Office located at: 122 Northern Avenue, Gardiner, Maine
Email: voni.a.eames@maine.gov

<p style="text-align: center;">APPLICATION INSTRUCTIONS ALCOHOL AND DRUG COUNSELING AIDE</p>

1. Complete and sign the application (make sure the Board-Certified Clinical Supervisor portion has been completed and signed by your Board-Certified Clinical Supervisor.)
2. Submit a copy of birth certificate, driver's license, or passport.
3. Submit documentation of graduation from High School or equivalent GED certificate or official transcripts (see 32 MRSA § 6214-C).
4. Submit a copy of driving record from the Maine Department of Motor Vehicles (or appropriate agency if you are from another state).
5. Submit verification from every state in which you currently hold or have ever held any type of professional license (except Maine).
6. Submit the fee of \$115.00 (\$25.00 non-refundable application fee, registration fee \$75.00 and criminal history record check \$15.00). If paying by check, make it payable to Treasurer, State of Maine. If paying by credit card, please submit the enclosed authorization form with your application

As an Alcohol & Drug Counseling Aide registrant (ADCA) you will be required to satisfy the Continuing Education requirements identified in Chapter 7 of the Board's rules. Please be sure to review this chapter carefully.

Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration **requires** a criminal history records check as part of the application process for each application filed with this office.

Public Law Chapter 401, sec. W-1, amends Title 25 §1541, sub-§6 to allow the State Bureau of Identification to charge a fee to government organizations for services provided. As of October 1, 1999, all criminal background checks of individuals are subject to a fee as determined by the Commissioner of Public Safety, which shall be \$15.00 as of May 1, 2003.

The Board of Alcohol and Drug Counselors requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted.** Documents that have been modified or altered in any way will not be accepted.



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AND FINANCIAL REGULATION
STATE BOARD OF ALCOHOL AND DRUG COUNSELORS
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AUGUSTA, MAINE
04333-0035

Direct Tel: (207) 624-8689 Receptionist: (207) 624-8603
FAX: (207) 624-8637- TTY/ Hearing Impaired: 1-888-577-6690

JOHN ELIAS BALDACCI
GOVERNOR

Office use only
Cash # _____
License#: _____
4350 1446 \$25.00
4350 1424 \$75.00
4350 2619 \$15.00

ANNE L. HEAD
DIRECTOR

APPLICATION FOR ALCOHOL & DRUG COUNSELING AIDE

Application Fee: \$ 25.00
License Fee: \$ 75.00
Criminal History Record Check Fee: \$ 15.00
TOTAL FEE DUE: \$115.00

Please Make Check Payable to Treasurer, State of Maine
or completed credit card authorization form

Name: _____
First Middle Initial Last

Any Other Names Used: _____

Contact Address: _____
Street/Box City State Zip Code County

Contact phone: _____ Email Address: _____

Date of birth: _____ Social Security #: _____

Have you ever been licensed for any profession in any jurisdiction of the United States, including
Maine, or any country? ____Yes ____No
If yes, (list all issued)

Including Maine list each state or other jurisdiction in which you hold or have ever held any
type of professional credential or license

<u>State</u>	<u>License Type</u>	<u>License Number</u>	<u>Expiration date</u>

ATTACH A SEPARATE SHEET IF NECESSARY

** You must also send the enclosed **Verification of Licensure** form to any other credentialing or
licensing body where you hold or have held a license or credential, please follow directions on the
form.

AFFIDAVIT/DISCIPLINARY RECORD

Check appropriate response to the questions. Any **YES** response must be fully explained by written statement on a separate sheet of paper, signed and dated, and submitted with your application.

HAVE YOU EVER:

1. Been convicted of any criminal offense (including motor vehicle offenses, but not including minor traffic or parking violations)? ☐ YES ☐ NO
(If YES, please attach a detailed explanation and provide a copy of the court judgment/disposition.)
2. Had any state or territory EVER deny your application for any type of professional license, certificate or registration, or taken any disciplinary action against the license issued to you in that jurisdiction (including, but not limited to, warning, reprimand, fine, suspension, revocation or restrictions in permitted practice, probation with or without monitoring)?
☐ YES ☐ NO
3. Received a sanction from Medicare or from a state Medicaid program?
☐ YES ☐ NO
4. Had hospital or similar health care institution privileges ever been denied or which had previously been granted to you suspended, restricted or withdrawn involuntarily; or have you ever voluntarily surrendered privileges or resigned from staff membership while under peer review?
☐ YES ☐ NO ☐ N/A
5. Had a judgment alleging malpractice liability, a claim settlement by negotiation/arbitration or judgment by a court in a claim of professional malpractice liability in which you are/were named as a defendant with any degree of liability including "nuisance" suits and including settlements made by your insurance company/representatives without your express consent?
☐ YES ☐ NO ☐ N/A

Notice regarding Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

Notice regarding Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State's website.

I hereby certify that the above statements are accurate and represent a true statement of fact. I further certify that I have read, understand, and agree to uphold the counselor code of ethics as it appears in the rules of the board. By the fact of this application, I waive objection and authorize the board to make such inquiries, and have access to such information as the board may consider necessary to determine good character and suitability.

SIGNATURE OF APPLICANT

DATE

Full Name of present agency you are employed at : _____

Agency License Number: _____ Agency Expiration Date: _____

**If the agency has an expired license a copy of the agency's authorization (extension letter) to continue to operate must be submitted with this application.

EMPLOYERS ARE REQUESTED TO NOTIFY THE BOARD SHOULD AN EMPLOYEE LEAVE HIS/HER JOB FOR ANY REASON.

THIS SECTION TO BE COMPLETED BY THE BOARD-CERTIFIED CLINICAL SUPERVISOR:

My signature attests to the present employment of _____ as an alcohol and drug counseling aide and that the requirements of the position conform to the Board's definition of an alcohol and drug counseling aide as listed below. The verification of employment as an alcohol and drug counseling aide includes minimum criteria:

Please refer to 32 MRSA § 6203 (1-C) for information on the scope of practice for an Alcohol and Drug Counseling Aide.

SIGNATURE AND TITLE

DATE

CONTACT ADDRESS

CONTACT PHONE NUMBER

LICENSE TYPE

LICENSE NUMBER

VERIFICATION OF LICENSURE

To be completed by applicant prior to mailing to each state in which you now hold or have ever held a license to practice. Please print. (This form may be copied as necessary)

Name: _____

—

Address: _____

(state) (zip code) Date of Birth: _____

License #: _____ Date

Issued: _____

I hereby authorize the Licensing Authority of the State of _____ to furnish to the Maine State Board of Alcohol and Drug Counselors the information requested below.

Applicant Signature: _____ Date: _____

To be completed by the State Licensing Board or Credentialing Agency verifying the above information. Please complete this section and return to the applicants address above:

LICENSING BOARD OR AGENCY: This is to certify that the above-named individual was issued License or License/Credential# _____ to practice as a _____ on:

(date issued) _____ (expiration date) _____

Basis of Licensure:

- ☐ Examination: Indicate the year examination taken and by what State Licensing Board or Credentialing Agency.
- ☐ Grandfathering: Provide documentation of licensure/credentialing requirements at time of initial issuance
- ☐ ICRC Written Examination: _____ ☐ CPM Oral: _____
- ☐ State Exam _____ ☐ CCS Written Examination: _____
- ☐ Other _____
- ☐ Endorsement from _____ (Indicate state)
- ☐ Waiver - Indicate on what basis: _____

Status of License: ☐Active ☐Inactive ☐Lapsed ☐Other: _____

Date license expires/d: _____

Disciplinary Action: Has this license ever been revoked, suspended, limited, surrendered, restricted, placed on probation, encumbered in any way? ☐Yes ☐No

If yes, please attach a copy of the decision.

Signature: _____

Title: _____

State: _____

Date: _____

(SEAL)



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AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: (applicant fees being paid for)		
Contact Address: (applicant fees being paid for)		
City:	State:	Zip Code:
County:		Telephone:
Name of cardholder: (if other than applicant)		
Contact Address: (if other than applicant)		
City:	State:	Zip Code:

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ Visa ☐ MasterCard _____

Card number

Expiration date: ____/____/____ **in the amount of: \$** _____

Signature: _____ **Date:** ____/____/____

PHONE: (207)624-8689
(Office Phone)



PRINTED ON RECYCLED PAPER

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